problems of the elderly (such as incontinence, cognitive impairment and falls) are generally poorly understood by both medical residents and attending staff and that there is a place for specialized teaching to cover these deficits.

The program does have one unassigned elective period, and for a resident with a special interest in geriatrics such a rotation would be encouraged. In spite of mounting pressure I am unconvinced that such a rotation should be mandatory for all residents. It is interesting that the certifying bodies have not declared themselves in this regard.

Dr. Trimble is entirely correct, and I thank him for his clarifications.

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Loxoscelism in Canada

Drs. Greg A. Baldwin, David F. Smith and Stanley Douglas Fike have presented two interesting instances of envenomation by the *Loxosceles* spider in Canada (*Can Med Assoc J* 1988; 138: 521-522). The treatment results are none too encouraging. Could it not be that, at least in part, reliance on surgical excision and the use of steroids contributed to the poor outcome? Poor results after surgical excision of the affected area are most commonly reported,[1-3] and it has been pointed out that steroids are not effective in the management of such cases.[4,5]

The mechanism of action of the *Loxosceles* toxin is complex and most likely involves some kind of host immune reaction.[1,6] It is quite possible that such a reaction is responsible for the wide variability in tissue damage seen after a *Loxosceles* spider bite. Alternatively one might consider the possibility that the spider does not inoculate each victim with the same amount of venom (a fact for the Crotalidae family of snakes).

Finally, in view of the host immune response, local and systemic administration of dapsone would appear to be a reasonable first choice.[2,7]

One is reminded of the controversy surrounding the competing claims between immediate surgical excision of the area of a crotalida bite and large doses of immune serum, which has now been resolved in favour of the latter. One would like to hope that in the case of *Loxosceles* bites such a waste of time and energy could be avoided through a clear-headed approach.

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[Drs. Smith and Baldwin reply:]

Our two patients, initially seen in 1984, were treated by what were felt to be accepted methods at that time. In one patient this included steroid therapy, excision of dead tissue and grafting, along with systemic support. We recognize that the tissue necrosis in such cases is variable and does not occur with all bites from the brown recluse spider. The extent of treatment depends on the degree of tissue damage, the amount of envenomation, the site of the bite and various other factors.

Dr. Boba is correct in pointing to recently recommended alternative forms of therapy — specifically, the use of injected dapsone, a drug more commonly known for its use in leprosy. Dapsone may prove to be the better form of initial therapy, as indicated in King's summary.[1] Certainly King's experience is significant and offers more clinical material than other published reports.

We would like to draw attention to a paper reporting six cases of class 3 or 4 envenomation treated with hyperbaric oxygen; all the lesions healed promptly without surgery, third-degree skin sloughing or significant scarring when hyperbaric oxygen therapy was instituted 2 to 6 days after the bite.[2] The author raised the question whether these very positive results were due simply to oxygenation of an ischemic wound or also to in-vivo deactivation of the necrolytic component of the venom.

We believe that the optimum treatment of *Loxosceles* spider bites remains controversial because of a lack of controlled studies and, hence, conclusive data. With our limited Canadian exposure, such studies need to be performed in areas of greater prevalence, such as the south-central and southeastern United States.

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